



IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH - Governor
RICHARD M. ARMSTRONG - Director

DEBBY RANSOM, R.N., R.H.I.T. - Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

December 19, 2006

FILE COPY

Lisa Junod, Administrator
Rosetta Assisted Living-Creekview
1970 E 17th St #103
Idaho Falls, ID 83404

License #: RC-691

Dear Ms. Junod:

On November 2, 2006, a state licensure survey was conducted at Rosetta Assisted Living - Creekview. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted evidence of resolution.

Should you have questions, please contact Rebecca Winter, RN, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

REBECCA WINTER, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

RW/slc

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Community Care Program



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November 6, 2006

Lisa Junod, Administrator
Rosetta Assisted Living - Creekview
1970 E 17th St #103
Idaho Falls, ID 83404

Dear Ms. Junod:

On November 2, 2006, a State Licensure survey was conducted at Rosetta Assisted Living - Creekview. The facility was found to be providing a safe environment and safe, effective care to residents.

The enclosed form, stating no core issue deficiencies were cited during the survey, is for your records only and need not be returned.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by December 2, 2006.

Should you have any questions about our visit, please contact me at (208) 334-6626.

Sincerely,

A handwritten signature in black ink, appearing to read 'JS' or 'J. Simpson', written in a cursive style.

JAMIE SIMPSON, MBA, QMRP
Supervisor
Residential Care Assisted Living Program

JS/slc

Enclosure

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R691	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/02/2006
NAME OF PROVIDER OR SUPPLIER ROSETTA ASSISTED LIVING - CREEKVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 5685 BANNOCK HIGHWAY SOUTH POCATELLO, ID 83204		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
R 000	<p>Initial Comments</p> <p>The residential care/assisted living facility was found to be in substantial compliance with the Rules for Residential Care or Assisted Living Facilities in Idaho. No core issue deficiencies were cited during the standard health survey conducted at your facility. The surveyors conducting the standard health survey were:</p> <p>Rebecca Winter, RN Team Coordinator Health Facility Surveyor</p> <p>Rae Jean McPhillips, RN Health Facility Surveyor</p> <p>Karen McDannel, RN Health Facility Surveyor</p>	R 000			

Bureau of Facility Standards

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

5JHM11

If continuation sheet 1 of 1



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ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name <i>Rosetta Assisted Living Creekview</i>	Physical Address <i>5685 Bannock Hwy S.</i>	Phone Number <i>239-0480</i>
Administrator <i>Lisa Tunod</i>	City <i>Pocatello</i>	ZIP Code <i>83204</i>
Survey Team Leader <i>Rebecca Winter</i>	Survey Type <i>Standard</i>	Survey Date <i>11/2/06</i>

NON-CORE ISSUES

ITEM #	RULE #	DESCRIPTION	DATE RESOLVED	BFS USE
1.	260.06	The bathroom in room 9 had urine and bowel movement stains on the toilet seat, and urine stains around the toilet on the floor. Additionally, there was a strong smell of urine.	12/1/06	pu
2.	300.01	The facility did not delegate all nursing functions to 3 of 3 caregivers-records reviewed.	clarified exit cited.	Not pu
3.	405.05.a	a. A wheel chair was placed in the doorway of a resident's room, therefore obstructing exit access.	12-1-06	pu
4.	450.	The facility did not meet the standards of the Idaho Food Code, as follows: - 2 of 2 refrigerators did not maintain foods at the required temperature. - single use gloves were used for multiple tasks, and therefore were contaminated. - The person in charge could not (continued)	12-1-06	pu
Response Required Date <i>12-2-06</i>		Signature of Facility Representative <i>T. J. [illegible]</i>	Date Signed <i>11-2-06</i>	



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NON-CORE ISSUES

ITEM #	RULE #	DESCRIPTION	DATE RESOLVED	BFS USE
4	450(continued)	describe the symptoms associated with the diseases that are transmittable through food.		on page 1 pu
5	625.01	Personnel did not receive 16 hours of orientation training.	12/14/06	pu
6	630	Personnel did not receive specialized training in the areas of Dementia and Mental Illness, to include all topics specified.	12/14/06	pu
7	640	Each employee did not receive 8 hours of continuing training per year.	12/1/06	pu
8	730.01	Personnel records (3 of 3) did not contain documentation by the RN of delegation to unlicensed staff for all nursing functions.	clarified at exit. not cited. RW	

Response Required Date

12-2-06

Signature of Facility Representative

[Signature]

Date Signed

11-2-06